Arkansas Insurance Department

PY 2024 SERFF

Network Adequacy Data Submission Instructions

Version 2.2

Revision History

Version	Author	Change	Date
1.0	Tonmoy Dasgupta	First release	2/19/2017
1.1	Tonmoy Dasgupta	Appendix 2 added to enable NA data submission earlier than the rest of the data.	4/13/2017
1.2	Tonmoy Dasgupta	School Based Template instructions changed because the PY2018 ECP/NA template cannot be used as in the prior year's process. The directory has been changed into a template.	4/19/2017
1.3	Tonmoy Dasgupta	Appendix 2 updated after observing an issuer's failure to submit	5/4/2017
1.4	Tonmoy Dasgupta	Deferment of process 3.b	5/17/2017
1.5	Tonmoy Dasgupta	Removed school based data submission requirements. Update on process 3.b (no mid-year ECP/NA data submission required). Removal of Appendix 2 (Work-a-round for a problem in PY2018). Beefed up explanation for Network ID template because of frequent errors by issuers new to NA reporting	3/13/2018
1.6	Tonmoy Dasgupta	PY2020 release with version update. No material changes.	12/18/2018
1.7	Tonmoy Dasgupta	1-3) Process 3.a-3 (Added "Other Health Plans…")	8/8/2019
1.8	Tonmoy Dasgupta	PY2021 release with version update. Sampling size for county with no members changed in 2.1	12/16/2019
1.9	Tonmoy Dasgupta	PY2022 release only with version update- no material change.	11/30/2020
2.0	Tonmoy Dasgupta	PY2023 release with version update. Section 1.3 updated to correct anytime submission only for Large Group. Section 1.3.1 SERFF file name change. Section 1.3.3 reference to Rule 106 Section 3-I changed to 3-J with updated Rule.	3/10/2022
2.1	Tonmoy Dasgupta	*AR Network Adequacy Supplemental Template* has been added after it was discovered that the PY2023 CMS-CCIIO ECP/NA template had removed the "Pharmacy" and "Other" categories, preventing Issuers from reporting provider types that Arkansas monitors but CMS does not.	5/2/2022
2.2	Tonmoy Dasgupta	PY2024 release only with version update- no material change.	3/14/2023

Contents

1. Background:

AID's Network Adequacy (NA) annual review consists of three distinct processes. The purpose of this document is only to expand on data submissions in Process 3.a described below. Process 1 & 2 are summarized for information only.

1) Process 1: In this process the Arkansas Insurance Department (AID) reviews the Provider Types list (*For example, Access to Oncologists, OB/GYN etc.)* that will be monitored for Network Adequacy in the oncoming Plan Year. Provider Types may be added or deleted for a Plan Year. These Provider Types are decided by AID in collaboration with Arkansas Department of Health (ADH) and the Arkansas Center for Health Improvement (ACHI). An important part of this process is the definition of these provider types in terms of NUCC taxonomy codes. This list of provider types with their taxonomic definitions is then shared with the industry for comment. Finally, this is published as "*Provider Type Taxonomic Descriptions*" within the webpage http://rhld.insurance.arkansas.gov/Default/NetworkAdequacy . Processes 2 and 3 are dependent on the outcome of this process.

2) Process 2: In this process, AID facilitates industry maintenance of the Provider-Type-NPI-Pools (PTNPs) data for uniform interpretation of provider classification(s). This data maintenance process occurs twice a year because of the dynamic nature of provider networks. The first round ends early in the year with publication of the *Finalized Provider Type-NPI List* for the on-coming Plan Year in AID's web location http://rhld.insurance.arkansas.gov/Default/NetworkAdequacy . The *Finalized Provider Type-NPI List* is commonly called the "Provider-Type-NPI-Pools" or (PTNPs). Process 3 is dependent on this data artifact.

   The PTNPs are updated again later in the year through a second round of provider classification data maintenance.

3) Process 3.a: This process is essentially data preparation and submission (NA data included) for plan certification. Issuers prepare and submit NA data followed by AID review. All data submissions in this process occurs within the SERFF application maintained by NAIC. This process starts with release of the *Requirements for Qualified Health Plan Certification* for the oncoming Plan Year (For example 3-2016 Bulletin *"2017 Plan Year Requirements for Qualified Health Plan Certification"* published on March 1, 2016) and ends with the certification, decertification, or withdrawal of the submitted plans. This process may start at any point in the year for a large group though we encourage submission at the same time as the others, if possible, for review efficiency.

Network Adequacy data submitters are categorized into three groups because of differing requirements

1) **<u>QHP Plans On Marketplace (Individual and SHOP) & Stand Alone Dental Plans (On-Marketplace and Off-Marketplace-seeking-certification):</u>**

All NA data artifacts needed by AID from the issuers for this process are listed in the spreadsheet titled *PY <applicable Plan Year in YYYY format> AID QHP SADP Plan Management Submission Requirements BY DATE* located in the Plan Management General Instructions section within SERFF.

2) **<u>Off-Marketplace Medical Plans:</u>**

All NA data artifacts needed by AID from the issuers for this process are listed in the spreadsheet titled *PY<applicable Plan Year in YYYY format> AID Off-Marketplace Binder Submission Requirements* available in the Plan Management General Instructions section within SERFF.

3) **<u>Other Health Benefit Plans as defined in Rule 106 Section 3-J:</u>**

Data requirements are limited to the following seven NA templates.

<u>AID authored templates</u>

1. AR Specialty Access Template
2. AR Justification Template (needed only if standards are not met)
3. AR Provider-Enrollee Ratio Template

<u>Federal (CMS) authored templates</u>

4. Essential Community Provider/Network Adequacy Template (ECP section is not applicable to plans that will not be certified as Qualified Health Plans)
5. Service Area Template
6. Network ID Template

Process 3.b: There is a mid-year review done by AID of certified plans that are in operation. This review does not require new data submissions. AID uses PTNPs and issuers' template data available across two successive plan years.

For those who are visually inclined, all of the above processes are explained using a swim lane process diagram in Appendix 1 of this document.

AID's maintains complete details of the NA Regulation program including meeting minutes within its NA home page at: http://rhld.insurance.arkansas.gov/Default/NetworkAdequacy.

2. Process 3.a template details:

This section elaborates on Process 3.a mentioned in Background Section 1 of this document.

AID reviews NA for a limited set of provider types (oncologists, endocrinologist etc.) each plan year. These provider types are decided by AID in collaboration with ADH and ACHI. AID's implementation of NA regulation makes use of a combination of Arkansas *and* Federal (CMS/CCIIO) designed templates. The subsequent sub-sections detail all data required for AID's NA review towards plan certification.

2.1 Use of AR Specialty Access Template:

The *PY<applicable Plan Year> AR Specialty Access Template* is located in the Data Specification webpage : http://rhld.insurance.arkansas.gov/Info/Public/Templates. Please read all instructional tabs before using this template.

Issuers are to report county level access data using the *AR Specialty Access Template* for provider types applicable to them (QHP, off-exchange Medical, or Dental only issuers). What provider type data is required from different types of issuers is detailed in the *DataDictionary1-Criteria* tab within the same template. The county level access data needs to be generated **using the latest PTNPs** published by AID, the provider's practicing locations and the enrollee's address. The PTNPs are created in Process 2 for uniform industry-wide provider data classification.

Issuers with no enrollees in any county (new issuers entering the state *OR* existing issuers expanding service to new counties) may use 0.5% of the county population as a sample base of membership for providing the distance access and coverage reports.

Explanation of how these Provider Type NPI pools would be used is explained with an example in Table 1.

Table 1: Generation of the "Access to Cardiologists" county statistical data
(It is expected that Data Specialists with data handling expertise would assist in the data preparation and processing.) **Look at all the NPI's listed against Criteria Code C060- "Access to Cardiologists" within AID's latest published spreadsheet *"Finalized Provider Type-NPI list"* (aka PTNPs). This NPI list would be the Cardiologist NPI Pool agreed to by industry. From this pool determine the subset of NPIs belonging to the plan's network (in-network providers). Using this in-network NPI subset, find all associated address for the provider's practice. Feed this NPI subset along with the location data to NA programs (such as Quest Analytics etc.) to generate the county statistical data for "Access to Cardiologists" for data reporting.**

AID may validate issuer's *AR Specialty Access Template* county level summarized data using provider practicing location data within the Federal template *Essential Community Provider/Network Adequacy Template* and the latest PTNPs data.

2.2 Use of the *AR Justification Template*:

The *PY <applicable Plan Year> AR Justification Template* is located in the Data Specification webpage : http://rhld.insurance.arkansas.gov/Info/Public/Templates. Please read all instructional tabs before using this template.

AID requires issuers to provide justifications if standards are not met or objections are raised by AID using the *AR Justification Template.*

AID requires up-front justification from the industry on failure to meet either of the two conditions in the table below for any provider type in any county. The term "up-front justification" refers to justification provided by the issuer *at the time of data submission before AID has reviewed the data*. The table below describes the triggers for which up-front justifications are required. In the table below, Medicare county classifications are grouped as non-Rural and Rural counties.

Triggers for Up-front justification

	Large, Metro & Micro county (non-Rural group) threshold	Rural & CEAC county (Rural group) threshold
Average distance to 1st provider *exceeds*	Standards set in Rule 106 for different provider types (generally 30 miles for non-specialists and 60 miles for specialists)	20% in excess of the non-rural standards set in Rule 106 for different provider types (generally 36 miles for non-specialists and 72 miles for specialists)
Percentage of enrollees within distance standard *is below*	80%	80%

The table above is explained with examples of when up-front justifications are required:

1) Issuer ABC "Average Distance to 1st Provider" for Oncologists in Mississippi County is 65 miles and it covers 81% of its enrollees. Since Mississippi County is a Rural county, the threshold distance requirement for Oncology specialists is 72 miles. ABC meets both conditions within the table and an up-front justification **is not required**.
2) Issuer ABC "Average Distance to 1st Provider" for Oncologists in Faulkner County is 65 miles and it covers 81% of its enrollees. Since Faulkner County is a non-Rural county, the threshold distance requirement for Oncology specialists is 60 miles. ABC fails to meet the average distance criterion within the table and an up-front justification **is required**.
3) Issuer ABC "Average Distance to 1st Provider" for Oncologists in Faulkner County is 56 miles and it covers 81% of its enrollees. Since Faulkner County is a non-Rural county, the threshold distance requirement for Oncology specialists is 60 miles. ABC meets both conditions within the table and an up-front justification **is not required**.
4) Issuer ABC "Average Distance to 1st Provider" for Oncologists in Faulkner County is 56 miles and it covers 75% of its enrollees. Since Faulkner County is a non-Rural county, the threshold distance requirement for Oncology specialists is 60 miles. Though the distance criterion is met by ABC, the

county fails to meet the percentage of enrollees covered criterion and an up-front justification **is required**.

2.3 AR Provider-Enrollee Ratio Template

The *PY <applicable Plan Year> AR Provider-Enrollee Ratio Template* is located in the Data Specification webpage: http://rhld.insurance.arkansas.gov/Info/Public/Templates. Please read all instructional tabs before using this template.

AID requires QHP and off-exchange medical issuers to furnish provider-enrollee ratios for certain Provider Types at the service area level. If the issuer operates throughout the state, they would provide state level data whereas issuers providing service in a limited set of counties would provide data at the combined county level for that set of counties. These ratios display the number of providers for every 1,000 enrollees. AID has chosen the 2017 Medicare Advantage standards in consultation with the industry to determine minimum requirements in certain provider types as listed in the table below.

		AID Requirements on Provider-Enrollee ratios	
CriteriaID	**Criteria Reference**	**non-Rural**	**Rural**
C010	Access to Adult/Geriatric Primary Care Providers	1.67	1.42
C020	Access to Pediatric Primary Care Providers	0.84	0.71
C040	Access to Mental Health/Behavioral Health Providers	0.14	0.12
C050	Access to Substance Use Disorder Providers	0.14	0.12
C060	Access to Oncologists	0.25	0.21
C080	Access to Cardiologists	0.27	0.23
C090	Access to OB/GYN	0.84	0.71
C100	Access to Pulmonologists	0.13	0.11
C110	Access to Endocrinologists	0.04	0.03
C220	Access to Rheumatologists	0.07	0.06
C230	Access to Ophthalmologists	0.24	0.20
C240	Access to Urologists	0.12	0.10

Issuers with no enrollees in any county (new issuers entering the state or existing issuers expanding service areas) may use 0.05% of the non-elderly (under 65 years) county population for all counties that comprise their service area as a base of membership for providing reports and determining the ratios for network providers.

This template provides an opportunity to the issuers to convey justifications if unable to meet either the Rural or non-Rural requirements. The “non-Rural” counties are those counties that Medicare classifies as *Large, Metro or Micro* and “Rural” counties are those that Medicare classifies as *Rural or CEAC.*

2.4 Essential Community Provider/Network Adequacy Template

The *Essential Community Provider/Network Adequacy Template* (ECP/NA Template) is a Federal template. **Off-marketplace issuers are not required to fill in the Essential Community Provider (ECP) part of the template but all issuers are required to provide data within the tabs "*IndividualProviders*" and "*Facilities&Pharmacies*".**

This document does not provide detailed guidance on how to complete this ECP/NA Template. Please refer to appropriate CMS/CCIIO documentation for details.

This ECP/NA Template provides all practicing locations of providers (one row for every practicing location for each NPI). This data is crucial for geo-analysis and other checks within AID's NA program. Among other details, it is important to accurately attribute each NPI as either an individual provider or a facility within this ECP/NA Template.

2.5 Service Area Template

The *Service Area Template* is a Federal template. AID's implementation of NA requires this template irrespective of whether the plan is in the marketplace or not. This document does not provide detailed guidance on how to complete this Federal template. Please refer to appropriate CMS/CCIIO documentation for details.

This template displays the geographical area the plans within a binder intend to cover. Some plans may service the entire state while some may service limited parts of the state and this template communicates this information.

2.6 Network ID template

The *Network ID Template* is another Federal template. AID requires this template for its implementation of its NA program *only if the plans within a SERFF binder use different networks for different plans* (**This is unusual for Medical and QHP plans**; AID has not come across such cases so far at the time of drafting this document). **If multiple networks do exist, besides providing this template, the data rows in all other templates mentioned so far must identify the network the data belongs to.** Each of the templates have a column for Network ID to accommodate such a situation. *For example, if an issuer does have two different networks servicing different plans within the binder, with network IDs ARN001 & ARN002, they must for example report the "Access to Cardiologists" in the AR Specialty Access Templates separately for each of the networks.*

This document does not provide detailed guidance on how to complete this Federal template. Please carefully refer to appropriate CMS/CCIIO documentation for details. **AID has observed frequent mistakes by issuers in the past in understanding this template and have reported multiple Network IDs when it did not apply.** Some issuers have incorrectly reported each constituent contractor used to build their network with a different network id. If an issuer uses multiple contractors to build a network, and that aggregated network is used in all plans within the binder, the issuer needs to report that as one network with one network id. If the issuer has different networks covering different plans in the same service area, within the binder, you have a case of reporting the different networks with different

network ids. Issuer should refer federal documentation for a complete understanding when multiple network IDs apply.

2.7 AR Network Adequacy Supplemental Template

The *AR Network Adequacy Supplemental Template* is a workaround created when for PY2023, the Federal ECP/NA template was found to have restrictions that disallowed Pharmacy Facility Type in the Facilities tab. Furthermore, the catch-all "Other" Facility/Individual Provider type has also been removed. This new AR template is not meant to *replace* the CMS-CCIIO PY2023 template but to report providers that cannot be reported in their PY2023 template. Please do not duplicate the NPIs that have already been reported in the Federal ECP/NA template. In the past, the Insurance Department has had to run ad-hoc analysis for provider types it does not explicitly monitor, and could use the NPIs in this template, map them to other external NPI classifications for ad-hoc analysis, should the need arise.

This template has two tabs that are the exact replica of the Federal template without the controls around the Facility Type Column or (Individual Provider) Specialty Type column. All columns other than the aforementioned have the same definitions as in the CMS/CCIIO documentation for the ECP/NA Template.

Issuers should report provider and facility practicing locations in Arkansas (and bordering States if the issuer wishes to report them especially if they have been used in average mile calculations as reported in the *AR Specialty Access Template*).

Appendix 1

This diagram visually explains the processes described in Background; section 1. Process 1 is color coded purple, Process 2 is colored blue, Process 3.a. is colored green and Process 3.b. is colored orange.